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## Alternatives to the in-person anaesthetist-led preoperative assessment in adults undergoing low-risk or intermediate-risk surgery. A scoping review: putting an end to 'semper idem'

Corina M. Bello, Michael A. Harnik, Markus M. Luedi and Thomas Heidegger

From the Department of Anaesthesiology and Pain Medicine, Inselspital, Bern University Hospital, University of Bern, Bern (CMB, MAH, MML) and Department of Anesthesiology, Spitalregion Rheintal, Werdenberg, Sarganserland, Grabs, Switzerland (TH)

Correspondence to Dr Corina M. Bello, MD, Department of Anaesthesiology and Pain Medicine, Inselspital, Bern University Hospital, University of Bern, Freiburgstrasse, 3010 Bern, Switzerland.
E-mail: corina.bello@insel.ch

Editor,

We read with interest the study by Jonker *et al.* entitled 'Alternatives to the in-person anaesthetist-led preoperative assessment in adults undergoing low-risk or intermediate-risk surgery. A scoping review'.[1] We congratulate the authors on this large-scale review comparing different alternatives to in-person preoperative visits regarding case cancellations, complications, financial burden or patient satisfaction. The authors argue, that regarding the outcome parameters mentioned above, a simple digital questionnaire represents an effective method for the preoperative assessment. Indeed, given the current financial and time constraints and limitations with outreach, such as during the recent global coronavirus disease 2019 (COVID-19) pandemic, it is important to consider alternatives to current standards of the preoperative evaluation. However, completely abandoning preoperative visits, may undermine important purposes of the preoperative appointments. We highlight three important considerations.

First, the conclusion of a superiority of a simple questionnaire is based on references. This warrants closer inspection: some of the studies assessing the questionnaire-based preoperative visit are dated and may be limited in the information about existent comorbidities. Additionally, some of the studies are based on surgical cohorts such as ophthalmology that involve patients with a lower surgical risk or exclude patients scheduled to undergo general anaesthesia. None of the older studies truly assessed patient satisfaction, one of the outcome parameters mentioned in Jonker *et al.*'s study.[1]

Second, as one of the cited studies in favour of the questionnaire-format from 1997 already stated, patient satisfaction needs to be assessed for sound evaluations of effectiveness and efficiency of preanaesthesia clinics.[1]

Conclusive studies assessing patient satisfaction with the preoperative evaluation process are currently lacking. Contrary to Jonker *et al.*'s results,[1] telephone-based rather than questionnaire-based preoperative evaluations were preferred by patients in another large study.[2]

Third, apart from these discrepancies regarding alternative methods of preoperative assessment in current literature, insights on how to lead the preoperative conversations to achieve high patient satisfaction are missing. In fact, the most recent 'guidelines for preoperative evaluation of patients undergoing noncardiac surgery' still point towards the exact same open questions as in 1997, namely 'What information is needed and/or wanted by the patient? How should this information be presented to the patient?' as stated under the subsection of 'how patients should be informed'.[3]

Patient satisfaction is an important outcome parameter consisting of different dimensions, among which information/involvement in decision-making and respect/confidence play a key role.[4] Personal preferences, expectations and concerns such as anxiety and specific fears of surgery and anaesthesia need to be addressed at an early stage. In this regard, eHealth solutions are certainly not a 'one size fits all' approach, as was recently demonstrated in a study on chronic pain patients where acceptance of telemedicine negatively correlated with higher pain levels and anxiety.[5] A similar effect may be seen in anaesthesiology. The ideal means to effectively transfer information while maintaining high patient satisfaction[6] might be influenced by certain conditions such as preexisting anaesthesia-related anxiety.[7] Hence, the purpose of the preoperative visit should go beyond listing comorbidities and medications as the primary basis to inform decision-making on the anaesthesia methods. Instead, we believe it important to create a personal connection with the patient and tailor the conversation according to individual needs.[8] Individual demands regarding information need to be clarified at the preoperative visit. Although legal requirements dictate a certain formal content for the preoperative discussion, an understanding of the demand for information represents an important determinant of success in restructuring preoperative visits.

To sum up, the preoperative visit offers a great opportunity to foster trust in the patient–physician relationship. Research assessing patient demands for the content of information rather than changing the form of the preoperative evaluation or even a complete abandonment of this extremely valuable chance to connect with patients is urgently required. It is our duty as responsible, caring perioperative physicians, to act as leaders on the path from 'semper idem' (Latin for 'always the same') towards tailored patient care.

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# Response to: reply to: regional anaesthesia in patients on antithrombotic drugs

Torger Aarstad Aase and Leiv Arne Rosseland

From Division of Emergencies and Critical Care, Oslo University Hospital, Oslo, Norway (TAA, LAR), and University of Oslo, Oslo, Norway (LAR)

Correspondence to Leiv Arne Rosseland, University of Oslo, Oslo, Norway. E-mail: l.a.rosseland@medisin.uio.no

Editor,

We apologize to Kietaibl *et al.*,[1] the authors of 'Regional anaesthesia in patients on antithrombotic drugs: joint ESAIC/ESRA guidelines', for repeating our question about their new definition of a low dose of LMWH, previously brought to their attention in a letter to the Editor.[2]

To our surprise, the answer provided by the authors did not address the question we were keen to see discussed.[3] In their answer, they discussed 'the optimal time interval between low-molecular-weight heparin (LMWH) administration for venous thromboprophylaxis and neuraxial procedures'.

However, we remain worried about their new definition of a low dose of LMWH; 50 IU or less anti-Xa $kg^{-1}$ $day^{-1}$. Their new definition, extrapolated from enoxaparin data only, differs significantly from current guidelines and decades of clinical practice in the US, UK/Ireland, and Scandinavia.[4–6] No scientific evidence is offered to justify why a new stricter definition of a low dose of LMWH is needed.

In fact, the authors themselves quote dalteparin doses 5000 IU or less anti-Xa $day^{-1}$ as 'low dose' in their Evidence Summary on page 113, whereas their Recommendation no. 7 on the same page introduces their new definition of a low dose being 50 IU or less anti-Xa $kg^{-1}$ $day^{-1}$.

As we pointed out in our previous letter, this new strict definition of a low dose will increase the time interval from a typical thromboprophylactic dose of dalteparin; 5000 IU $day^{-1}$, to when a patient will be eligible for a neuraxial procedure, from 12 to 24 h (unless the patient weighs 100 kg, in which case they will probably be underdosed). Postoperative patients on a similar thromboprophylactic regimen will not be able to enjoy postoperative pain relief from an indwelling epidural catheter, the catheter will have to be removed before thromboprophylaxis can be instituted.

We urge the authors to reconsider their definition of a low dose of LMWH, or at the minimum, to provide evidence to support why so many patients need to be deprived of neuraxial analgesia or anaesthesia for 24 h after their last thromboprophylactic dose. They should also discuss why postoperative patients receiving thromboprophylaxis need to be deprived of concomitant epidural pain relief.

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